

EXHIBIT B



Data iSight Product and Methodology Inpatient Module

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Data iSight's Inpatient Module is available to address out-of-network inpatient facility claims before payment is made utilizing a patented methodology that is applied consistently to all claims for a particular client.

The Inpatient Module assigns to the inpatient claim a severity-adjusted Diagnosis Related Group (DRG). This allows Data iSight to build a national benchmarking group that contains claim and cost data for cases of like severity in hospitals with characteristics that match those of the hospital on the claim being analyzed. The Inpatient Module then benchmarks each severity-adjusted DRG to a national or peer group median cost value. The cost of care is determined by accessing cost reports from the Healthcare Cost Report Information System (HCRIS) cost reporting system. Costs of all comparison cases are then adjusted based on the hospital's wage index. In accordance with preselected parameters set by the client to meet its business needs, the initial target reimbursement amount is then calculated by applying the median medical benchmark costs and applying an additional margin factor. Any applicable override rules and/or inflation factors are then applied to arrive at the recommended reimbursement amount.

In summary, through the Inpatient Module, Data iSight recommends payment allowable amounts using publically-available hospital-specific cost-based data in which each claim is benchmarked to a national or peer group median cost value in accordance with client's preselected parameters ("Data iSight Reimbursement").¹

In addition to the actual Data iSight Reimbursement for each claim, the engine produces objective supporting data along with the rules used in calculation of the Data iSight Reimbursement and this information is available to all parties involved in the settlement of the claim (payer, provider, and member) via HIPAA-compliant, secure web portals.

¹ The Data iSight Reimbursement does not reflect coinsurance, co-payment, deductible or non-covered provisions that may reduce the final payment amount.

I. History and Methodology Development

Data iSight was developed to address the need for a non-charge-based approach to reimbursement recommendation. Realizing that charges differed from area to area around the country, and that charge masters were outpacing inflation by a considerable margin, the objective from the outset was to provide a rational and repeatable methodology that used objective, publically-available data, and allowed for transparency to all parties. The methodology was also designed to enable a reimbursement that is profitable, rewards efficiency, and avoids bias from high and low charge locations.

During the development process, the Data iSight methodology was thoroughly researched by:

- Analyzing more than a quarter million claims and comparing costs and charges with reimbursement norms from various payer entities.
- Determining hospital profitability at an individual and peer group level
- Conferring with state regulators and hospital association groups and other industry leaders; and
- Reviewing historical data on reimbursements and appeals

On January 24, 2012, Data iSight obtained Patent No.: US 8,103,522 B1 for its methodology and process for calculating facility claim reimbursement recommendations that is applicable to this Inpatient Module, as well as to the Outpatient Module ("Patent").

II. Robust Source Data

The Inpatient Module uses a database that represents approximately 75% of all inpatient discharges in the United States. These files include:

- All Payer State Public Data
- MedPAR Data
- HCRIS Public Data
- Area Wage and inflation related data
- Provider of Service File

For each source of data, the files are analyzed by Data iSight to validate the information and remove any suspect or invalid data before including it in the Data iSight engine. Examples of typical data errors that are removed include:

- Zero charge records and negative amounts
- Invalid provider numbers
- Ungroupable inpatient claims

However, only records with incorrect data are excluded from the database. It is important to note that high and low dollar amounts on any code (*i.e.*, outliers) are not removed from the source data.²

The source data contains 12-24 months of data and it is updated semiannually or as updates become available from our supplier. Each update process includes archival of the aged data for reference if needed.

All-Payer State Public Data

Most states now require hospitals to submit inpatient information to a state agency. This data covers all discharges at the hospital, including Medicare and Medicaid, and all private payers. The dataset contains detailed claim information including:

- Diagnosis codes
- Procedure codes
- Charges at a revenue code defined department level rollup
- Length of stay

MedPAR Data

This is a national data set comprised of all Medicare inpatient discharge information

submitted for payment to CMS. Data is collected on a federal fiscal year basis and released for public use. By law, providers must bill Medicare the same amount as the general public. By referring to MedPAR charge data, we are able to view the provider's customary charge to the public as a whole.

The dataset contains detailed claim information including:

- Diagnosis codes
- Procedure codes
- Charges at a revenue code defined department level rollup
- Length of stay

HCRIS

Each hospital that is certified to handle Medicare patients is required to annually submit to CMS a very detailed series of financial and operational statistical reports that are collected and submitted to the Hospital Cost Report Information System (HCRIS). The cost information includes and pertains to all services rendered in the facility, regardless of payer.

These reports are developed, signed, and attested to by the hospital CFO. CMS follows a very involved audit process on these reports to validate their accuracy.

Provider of Service Files and Area Wage and Inflation

Support files are required to obtain facility information regarding address, zip code, area wage information, and inflation adjustment information. These files are updated yearly from CMS and the Federal Register.

III. The Process

Clients forward to Data iSight qualified out-of-network, non-contracted inpatient facility claims that have been reviewed by the client to determine eligibility, coverage, and if applicable, support of the Inpatient Module's methodology under the terms of the applicable

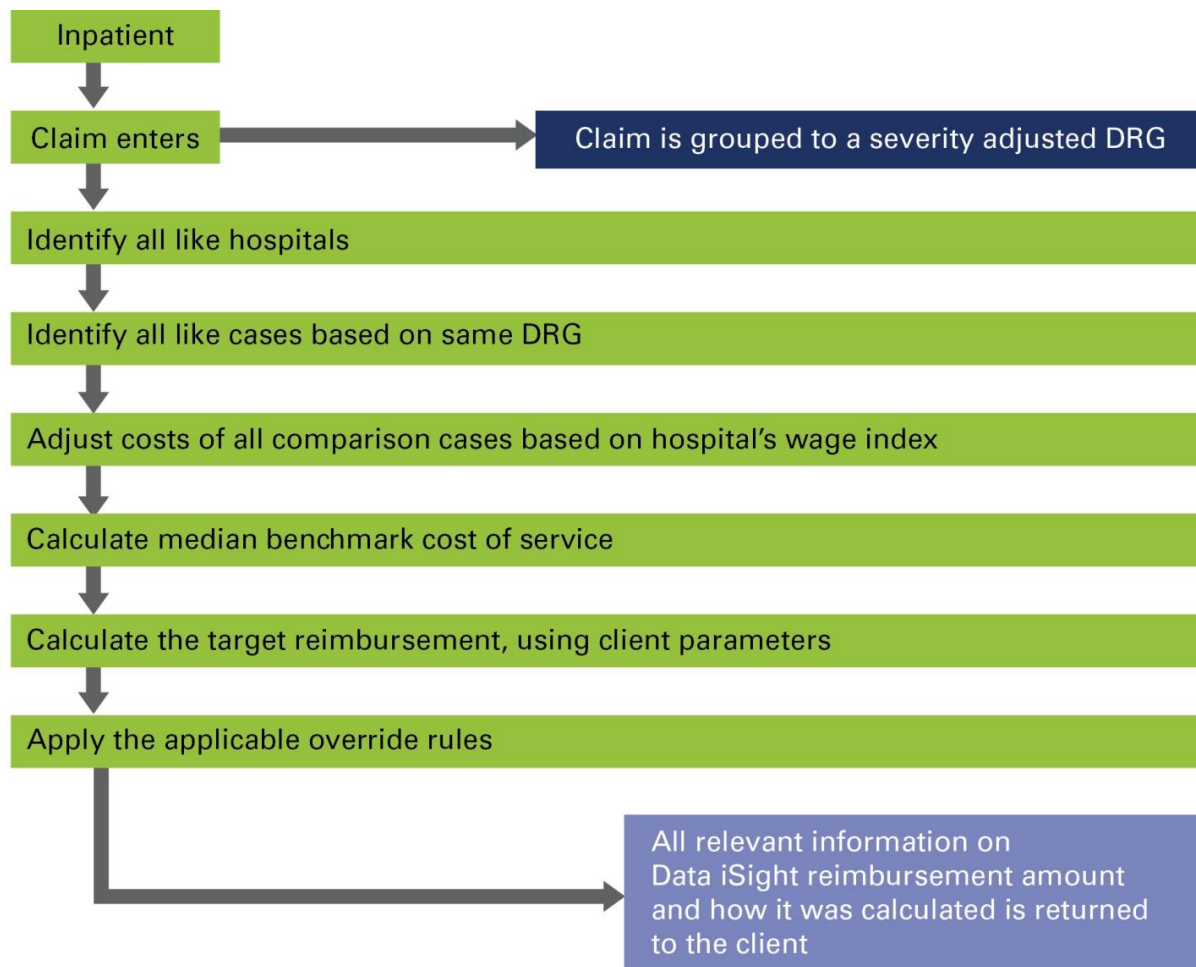
² The Inpatient Module source data does not include any OptumInsight (formerly known as Ingenix) ("Ingenix") data.

benefit program and other mutually-agreed referral criteria.

Data iSight first applies industry standard claim editing for inpatient claims (e.g., invalid codes,

age sex conflicts with procedures, ungroupable DRGs).

Next, Data iSight reviews the claims in accordance with the methodology depicted in the flow chart below:



Grouping the Claim to Severity Adjusted DRG/Determining the Clinical Severity of a Claim

The first step in the Data iSight process is to group the claim to a severity adjusted Diagnosis Related Group (DRG).

The original objective of diagnosis related groupings (DRGs) was to develop a patient classification system that related types of patients treated to the resources they consumed. Since the introduction of DRGs in the early

1980s, the healthcare industry has evolved and developed an increased demand for a patient classification system that can serve its original objective at a higher level of sophistication and precision.

The DRG assignment adjusts for severity by considering primary and secondary diagnosis and procedure codes, patient age, and discharge status to identify complications and co-morbid conditions which determine the specific severity level for each claim. The severity levels range

from 1 to 3. For example, the methodology will assign the severity of the patient being treated for a medical case as follows:

Patient A	no complication/ co-morbidity	Level 1
Patient B	with complication/ co-morbidity	Level 2
Patient C	with major complication/ co-morbidity	Level 3

A claim representing a severity level 2 case will only be compared with the level 2 cases in the comparison facilities. This classification allows Data iSight to build a benchmark group of like claims, for purposes of the clinical comparison.

Identifying Like Hospitals (Benchmarking) and Wage-Adjusting Costs of Like Hospitals

The next step in the process is for Data iSight to build the benchmark group of hospitals. The Cost Reports itemized in Section II provide information that allows Data iSight to categorize hospitals by key factors that are used to create a peer-to-peer comparison. The attributes used in the process are:

- urban or rural
- teaching or non-teaching
- bed size 0-150, 151-300, over 300

As a rule, Data iSight uses all of these criteria in determining “like” hospitals. This peer-to-peer comparison, or benchmark grouping, is a key differentiator in the Data iSight process.

The comparison is performed at a national level, as opposed to the regional approach. This results in a more robust set of claims for comparison. Since the cost of services varies widely based on regional differences in wage and other cost factors, the costs in the national benchmark group are adjusted, based on the CMS wage index, to match the wage index for the geographic location of the specific claim being analyzed.

When a claim is reviewed on a national level, the minimum number of matching cases in the peer group must reach 200. The peer group may be widened to include up to all hospital types nationally. In the event the minimum number of matching cases is not found, the claim will be returned for manual review.

If manual review fails to find a minimum number of matching cases, at client’s option, the claim may be returned to the client or negotiated.

Calculating the Median Benchmark Cost of the Service³

The next step is to calculate the median benchmark cost of the service. It is important to understand that the cost of service refers to the median cost of delivering care to the patient, and not the median charge that is passed through to the payer or patient. Specifically, the Data iSight methodology benchmarks the severity adjusted DRG on the submitted claim to a median cost value for the DRG on the comparison claims within the source data.

Cost of care for the benchmarked severity adjusted DRG is determined by accessing the HCRIS Report and costing the service at a departmental level and using facility and department level specific ratios. Specifically, as part of the HCRIS Report filed annually by each hospital, there is a schedule that documents very detailed department level charges and costs. From these charges and costs, ratios are developed that can be used to estimate the cost of an inpatient service using the revenue level charges from the claim.

Each claim is matched to the most appropriate cost report using the service dates from the claim. Cost ratios vary from facility to facility and from department to department. Each individual service is costed at a departmental level using facility and department level specific ratios. For each individual claim, Data iSight determines the cost by department and

³ Data iSight also estimates the cost of the services for the submitted claim as a reference point. It is not actually used to calculate the Data iSight Reimbursement amount.

summarizes the departmental charges to find the total estimated cost of that claim.

Missing Information Required for Repricing

The majority of claims have the required information for Data iSight. Attempts will be made to try to secure any missing claim information related to pricing. When information can't be acquired, a conservative proxy value may be derived. For example, if the Medicare ID needed to gather estimated cost is not available, the largest hospital in the ZIP or CBSA area may be used to calculate the Medicare value. The value should default to a conservatively higher value for the provider of service. This value will be subsequently marked up by the markup value and utilized when a benchmark cannot be determined.

Calculating Target Reimbursement in Accordance with Client Parameters

Once the median cost for the benchmark group is determined, Data iSight can calculate the Data iSight Reimbursement amount per the client's requirements. Our recommended methodology establishes a reimbursement amount equal to the median benchmark cost plus an additional margin factor, which is selected by the client based on the client's business needs. The median cost of all benchmark discharges is determined and the mark-up is applied. This methodology rewards more efficient hospitals.

While Data iSight does not mandate a margin factor, the system is set to default to a 125% mark-up. The 125% mark-up was established based upon historic accepted amounts for out-of-network claims. The rate was also influenced by retail out-of-network claims often being paid at a premium, the member's potential liability for balance billing up to billed charges, and the provider's profitability expectations. While Data iSight does not guarantee the provider's acceptance of any margin factor, the lower the margin factor the more likely the claim will be subject to provider complaint and challenge.

IV. Overrides and Alternative Pricing Methodologies

After the methodology is applied, overrides can be used to adjust the resulting price. Two standard overrides are always in place which establishes upper and lower limits for the Data iSight price:

- Never pay less than the amount at which 75% of hospitals in the benchmark group would make a profit
- Never pay more than billed charges

Clients may elect these additional overrides:

- Don't pay more than x% of the claim's Medicare reimbursement (*note: defaults to 250% if client elected*)
- Don't pay more than x% of the claim's cost
- Don't pay more than x% of the claim's charge
- Don't pay less than x% of the claim's Medicare reimbursement
- Don't pay less than x% of the claim's cost
- Don't pay less than x% of the claim's charge

Each override may be independently implemented if desired. Each override involves comparing the calculated reimbursement amount to the reimbursement amount based on the applicable override and then substituting the override reimbursement amount as applicable.

For example, with override (Don't Pay Less Than X % of Claim's Medicare Reimbursement), the calculated reimbursement amount is compared to the standard Medicare reimbursement amount for this type of claim, multiplied by X%. If the result of the comparison is that the calculated reimbursement amount is less than the X % of the standard Medicare reimbursement amount, X% of the standard Medicare reimbursement amount would be substituted for the calculated reimbursement amount.

In addition, if the client elects not to utilize the Data iSight methodology, at the client's option, one of following methodologies may be utilized to calculate the reimbursement amount based on the client's requirement. These can be used for all claims, or for claims meeting certain characteristics.

- x% of cost
- x% of Medicare
- x% of charge
- xth percentile of billed charges
- Averaged billed charges
- Level at which x% of hospitals are profitable

In summary, the Data iSight Inpatient Module offers numerous client-selected reimbursement methods and overrides that allow clients to specify requirements to meet their individual business needs.

V. Transparent Disclosure and Other Service Features

Data iSight offers complete transparency to all parties. The Data iSight Reimbursement and how it was calculated is available to the provider, payer, and member via a secured web portal.

With respect to the web portal, at the client's option the Repricing Statement and EOB direct providers and members to www.dataisight.com, where they follow prompts to pages that are customized for each audience. If a provider or member has been through this process, they will type in their user id and password to login; if this is the first visit, they will be led to a registration page.

Once logged in, they will see details supporting the Data iSight Reimbursement amount for their particular claim.

Depending on the claim, the detail may include:

- Provider billed charge and cost
- Benchmark charge and cost

- Number of cases and number of facilities in the benchmark group
- Medicare payment comparison
- Profit margins
- Data iSight reimbursement

The methodology report that may be generated from the portal includes details for the claim and its particular DRG. An additional note says:

For all comparison cases outside your community, amounts were adjusted using wage indices based on the prevailing practice and labor costs.

In addition, if elected by the client, Data iSight also provides Patient Advocacy and Provider Inquiry Management services. These services assist clients in proactively addressing and seeking to avoid the negative impact that may occur when a member is balance billed for amounts disallowed under the out-of-network provisions of the member's policy.